

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1.
  - a. Whether there should be additional reimbursement for date of service 06/21/01?
  - b. The request was received on 06/21/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC-60 and Letter Requesting Dispute Resolution
  - b. HCFAs
  - c. EOBs
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC-60 and Response to a Request for Dispute Resolution
  - b. Carrier marked Exhibits
  - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 07/31/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 07/31/02. The response from the insurance carrier was received in the Division on 08/13/02. Based on 133.307 (i) the insurance carrier's response is timely.

### **III. PARTIES' POSITIONS**

1. Requestor: letter dated 06/20/02  
"Codes 63042 and code 22820 were the only codes paid on both the posterior and anterior claims; both were paid at 100% if the TWCC fee guideline. However, although we tried, we have not been able to obtain further consideration of the codes 22612 and 63709 posterior, and the codes and[sic] 63090-58 and 22558-58 for the anterior portion of the surgery."

2. Respondent: letter dated 08/06/02  
“1. This carrier initially denied the charge for CPT code 22612, however, upon review reimbursement was made... 2. With regard to CPT code 63707...the requester is due NO additional reimbursement because the reimbursement for CPT code 63042 includes reimbursement for the repair of dural leak... 3. With regard to CPT code 22558-58...Modifier ‘58’ states, ‘Staged or Related Procedure or Service by the Same Physician During Postoperative Period... It is this carrier’s position that a staged or related procedure was NOT performed or documented. With regard to CPT code 63090-58...carrier’s position remains the same as the position stated for CPT code 22558.”

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1&2), the only date of service eligible for review is 06/21/01.
2. The Carrier’s EOBs have the denials:  
F – REIMBURSED IN ACCORDANCE WITH THE 1996 MEDICAL FEE GUIDELINE SURGERY SECTION GROUND RULE 1 D REGARDING MULTIPLE PROCEDURES.  
G – ACCORDING TO THE AAOS GLOBAL SERVICE DATA FOR ORTHOPEDIC SURGERY PUBLICATION THIS PROCEDURE IS AN INTEGRAL PART OF ANOTHER REIMBURSED PROCEDURE.  
N – DOCUMENTATION HAS NOT BEEN SUBMITTED TO SUBSTANTIATE THE SERVICE BILLED.
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	Carrier Denial	MARS	REFERENCE	RATIONALE:
06/21/01	22612	\$4883.00	\$0.00	F	\$2529.00	MFG, SGR (I)(D)(1)	The Carrier's response indicates that it has reimbursed this billed CPT code with check dated 10/09/01, check #08335783 at 50% of MAR due to the multiple procedure rule. This CPT code would be subject to the multiple procedure. Therefore, no additional reimbursement is recommended.
06/21/01	63707	\$3237.00	\$0.00	G	\$3237.00	Global Service Data for Orthopaedic Surgery (GSDOS), 1994	Per the GSDOS this billed CPT code is considered global to CPT code 63042 billed on the same DOS and reimbursed by the carrier. Therefore, no reimbursement is recommended.
06/21/01	63090-58	\$5985.00	\$0.00	N	\$4280.00	MFG, SGR (I)(D)(1) & CPT descriptor	The medical documentation states, "An osteotome was then used to remove portions of the vertebral body at L5. A second cut was made into S1. Perpendicular cuts were then made. These bone fragments were removed. Deeper cuts were then placed into L5 and S2. This bone was removed." The medical documentation indicates that the procedure was performed as billed. Therefore, reimbursement of \$4,280.00 is recommended.
06/21/01	22558-58	\$5134.00	\$0.00	N	\$2660.00	MFG, SGR (I)(D)(1) & CPT descriptor	The medical documentation indicates that the procedure was performed as billed. This billed procedure is subject to the multiple procedure rule and should be reimbursed at 50% of MAR. Therefore, reimbursement of \$1,330.00 is recommended.
<b>Totals</b>		\$19239.00	\$0.00				The Requestor is entitled to additional reimbursement in the amount of \$5,610.00.

The above Findings and Decision are hereby issued this 25<sup>th</sup> day of November 2002.

Larry Beckham  
Medical Dispute Resolution Officer  
Medical Review Division

### V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$5,610.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 25<sup>th</sup> day of November 2002.

Carolyn Ollar  
Medical Dispute Resolution Supervisor  
Medical Review Division